RHODE ISLAND DEPARTMENT OF HEALTH
Utilization Review Application Guidelines

The Rhode Island Department of Health (Department) provides the *Utilization Review Application Guidelines* as an outline for the utilization review application process, but these Guidelines do not replace or supersede Rhode Island General Laws 23-17.12, or its accompanying Rules and Regulations, R23-17.12-UR (UR).

ALL APPLICATIONS MUST BE FORMATTED ACCORDING TO THE FOLLOWING OUTLINE TO BE CONSIDERED FOR CERTIFICATION/RE-CERTIFICATION:

I. UTILIZATION REVIEW APPLICATION INFORMATION

TAB A: Application Information

- **$**500 application fee submitted with the utilization review application and made payable to "General Treasurer, State of Rhode Island" [UR 3.5.1]

  Note: In addition to the initial $500 application fee, the Department will bill the utilization review agency monthly for time spent on activities related to maintaining the certification. [UR 3.5.1]

- completed *Application for Certification/Re-certification to Perform Utilization Review* form [UR 3.1.1]

- completed *Application for Certification/Re-certification to Perform Utilization Review Assurances* form [UR 3.1.1]

- completed *Mandatory Addendum to License Application* [RIGL 5-75]

- evidence of current URAC accreditation, if applicable [UR 4.0]

  Note: The sections, as indicated by "[URAC waiver]" within these Guidelines, are waived for URAC-accredited applicants that do not perform utilization review for mental health and substance abuse services. If waived, incorporate policies and procedures applicable to URAC within the application.

TAB B: Ownership

- ownership listing & description, as described on the *Application for Certification/Re-certification to Perform Utilization Review* form [UR 3.1.1]

TAB C: Scope of Services

- a utilization review plan [UR 3.1.2]

- the scope of services provided in Rhode Island by the utilization review agency (e.g. medical, surgical, mental health, substance abuse, pharmacy, dental, vision, etc., for prospective, concurrent, and/or retrospective assessments) [UR 3.1.3]

- list of the entities for which the review agent is performing utilization review in Rhode Island and the services it is providing for each client [UR 3.1.9]

II. POLICIES AND PROCEDURES

Please provide copies of written, approved, and operational policies and procedures that comply with the following, for the utilization review agency applying for certification / re-certification.

TAB D: Quality Management Program

- a quality assurance program structured to monitor and evaluate the implementation of the agency's administrative and operational policies on an annual basis [UR 5.1.10]
  - include a Quality Management Program description

TAB E: Hours of Operation

- [URAC waiver] maintain a representative reasonably accessible to patients and providers for a minimum of 5 days per week, during normal business in the state of Rhode Island and during the agency's review operations [UR 3.1.6 a)]
- if the agency performs concurrent review, maintain an acceptable mechanism to conduct such concurrent review after the agency's normal business hours [UR 3.1.6 b)]

TAB F: Complaint Resolution

- a complaint resolution process for complaints other than medical necessity denial and appeals (e.g. quality of care, service, access, etc.) [UR 3.1.2 c)]

TAB G: Medical Necessity Standards and Screening Criteria

Note: review agents with annualized data reported to the Department totaling less than 500 requests for authorizations may request a variance, in writing, from sections 5.13 and 5.14 in accordance with section 12.0 [5.13.7]

- provide a description of utilization review standards, criteria, & guidelines used for medical, surgical, mental health, substance abuse, pharmacy, etc. [UR 5.1.4]
- [URAC waiver] establish and update criteria and review procedures with health care providers' consultation in the same specialty as would typically order the services subject to the criteria [UR 5.13.1]
- [URAC waiver] seek consultation on the criteria and procedures from at least 5 Rhode Island licensed providers and when applicable to inpatient and/or outpatient services of a hospital, with the Medical Directors of each Rhode Island licensed hospital [UR 5.13.2]
- [URAC waiver] maintain documentation of the comments submitted by the consultants and any actions taken by the UR agency to incorporate these comments/recommendations [UR 5.13.6]
- [URAC waiver] provide evidence of distribution of review criteria and procedures to each Rhode Island licensed hospital and the Rhode Island Medical Society upon application submission and within 30 days of implementing a change [UR 5.14]

TAB H: Adverse Determinations

- maintain clear documentation of the ordering provider's original requests and any negotiation/ agreement to accept an alternative treatment or modified extension of stay [UR 5.1.2]
- [URAC waiver] maintain documentation that the utilization review agency or its reviewers shall not impede the provision of health care services when the attending provider has determined the health care services to be an emergency [UR 5.1.5]
- [URAC waiver] that no prospective or concurrent adverse determination, and no

retrospective adverse determination for emergency health care services can be made, until there is evidence that an appropriately qualified and licensed practitioner with the same licensure status as the ordering practitioner, or physician or dentist, has communicated (telephone conversations, or fax/electronic transmissions) with the patient's attending practitioner [UR 5.2.2]
    - maintain documentation of agreed upon form of communication for fax or electronic transmissions [UR 5.2.2 a) ii)]
- [URAC waiver] no fewer than 2 documented attempts to communicate with the patient's attending provider, giving the provider sufficient time to respond after each attempt [UR 5.2.2 c)]
- all initial concurrent and prospective adverse determinations, and retrospective adverse determinations for emergency health care services are made, signed, and documented by a practitioner with the same licensure status as the ordering practitioner [UR 5.3.6]
- notification of prospective adverse determinations by the review agency shall be mailed or otherwise communicated to the provider of record and to the patient within 1 business day of receipt of all necessary information except for non-urgent or non-emergent cases which shall be communicated within 7 business days of receipt of all necessary information or prior to the proposed date of service if more than 7 days [UR 5.3.1]
- notification of concurrent adverse determinations shall be mailed or otherwise communicated to the patient and to the provider of record prior to the end of the current certified period [UR 5.3.2]
    - if financial arrangements between providers and payers determine that patients be held financially harmless, notice to the patients shall be provided within 1 business day of the final determination [UR 5.3.2 a)]
- the concurrent review process shall take into consideration the requirements of sections 5.2.5 b) i)-iv) & c) [UR 5.2.5]
- notification of retrospective adverse determinations shall be mailed or otherwise communicated to the patient and the provider of record within 30 business days of receipt of a request for payment and all supporting documentation for the covered benefit being reviewed [UR 5.3.3]
- a reasonable period of time for an appeal to be filed in order to be considered and that period shall not be less than 60 days from the date of notice of the adverse determination [UR 5.4.1]

TAB I: Appeals of Adverse Determinations

- no reviewer involved in prior reviews or direct patient care may participate in subsequent reviews [UR 5.7; UR 5.8]
- adverse decisions on appeal are made, signed, and documented by a practitioner with the same licensure status as the ordering practitioner [UR 5.4.4 a), b), c)]
- [URAC waiver] for retrospective adverse determinations for non-emergency health care services, no first level appeal decision may be made until there is evidence that an appropriately qualified and licensed practitioner with the same licensure status as the ordering practitioner has communicated with the patient's attending provider concerning the health care services [UR 5.4.4 d)]
- expedited review for emergencies must be provided on the first and second level of appeals with notification provided within 2 business days [UR 5.6]
- for first and second level appeals of concurrent and prospective reviews, written notification must be provided to patient and provider, no later than 15 business days after receipt of required documentation (if appeal notice is verbal and provided within the required timeframes, written notification to patient and provider may be given within 6

business days of verbal notice) [UR 5.4.3 a), c)]

- for first and second level appeals of retrospective reviews, written notification must be provided to patient and provider, no later than 30 business days after receipt of required documentation (if appeal notice is verbal and provided within the required timeframes, written notification to patient and provider may be given within 6 business days of verbal notice) [UR 5.4.3 b), c)]
- a reasonable period of time for a second or external appeal to be filed in order to be considered and that period shall not be less than 60 days from the date of notice of the adverse determination [UR 6.1.2 b)]

TAB J: External Appeals of Adverse Determinations

- an external appeal must be filed within 60 days of receipt of notice that the second level appeal has been denied [UR 6.1.2 a)]
- [URAC waiver] the utilization review agency will forward the following to the external appeals agency within 5 business days: the complete utilization review file, agency review criteria used in making the adverse determination, and payment for the review [UR 6.1.3; UR 6.1.4]
- [URAC waiver] emergency external appeals shall be made within 2 business days [UR 6.1.5]
- [URAC waiver] non-emergency external appeals shall be made within 10 business days [UR 6.1.6]
- [URAC waiver] if the decision of the utilization review agency is overturned by the external appeals agency, the appellant will be reimbursed by the utilization review agency within 60 days of the notice of the overturn for their share of the appeal fee paid [UR 6.1.2 c)]

TAB K: Roles and Responsibilities

- governing body or person responsible for utilization review operations [UR 3.1.4]
- medical director [UR 3.1.4]
- types, qualifications, and duties of utilization review staff [UR 3.1.4]

TAB L: Confidentiality

- assurance to all applicable state and federal laws to protect the confidentiality of medical records and individual health care information [UR 3.1.5; UR 5.12]
- process for reviewing information or data that is relevant to the utilization review process [UR 5.10]

TAB M: Assessments

- assurance that the utilization review agency and/or its reviewers will not engage in direct discussions and/or patient interview to assess the medical and/or mental health status of a patient [UR 5.1.6]
- all medical necessity assessments shall be made through chart review and discussion with attending provider and/or designee [UR 5.1.6 a)]

III. ADVERSE DETERMINATION NOTIFICATION LETTERS

TAB N: Sample Copies of Medical Necessity Denial Notification Letters

- Initial adverse determination letter (prospective, concurrent, and retrospective)

- Level I appeal denial letter
  - appellant has an opportunity to inspect and add information to the utilization review file for Level II appeal [UR 5.5.2]

- Level II appeal denial letter
  - instructions to initiate an external appeal that include the names of the state-designated external appeals agencies and the fees for completing such appeal [UR 5.9]
  - statement that if the decision of the utilization review agency is overturned by the external appeals agency, the appellant will be reimbursed by the utilization review agency within 60 days of the notice of overturn for their share of the appeal fee paid [UR 6.1.2 c)]

NOTE: All letters must [UR 5.3.4; UR 5.3.5]**:**

1. be on the utilization review agency's letterhead;
2. reflect actual letters that are sent to patient and provider, including fictitious names, reasons, etc.;
3. indicate a medical necessity denial/non-certification;
4. include a descriptive reason for the denial that is case-specific and criteria-specific (include clear information necessary for appellant to challenge the validity or application of the basis for decision);
5. provide instructions to initiate the next level of appeal that include a reasonable time period (at least 60 days from adverse determination notice) [UR 5.4.1]; and
   include contact information with a specific name, department, address, and phone number.

IV. ENROLLEE INFORMATION

TAB O: Informational Materials

- [URAC waiver] copies of UR informational materials distributed to enrollees with an explanation of the method of distribution [UR 3.1.7; UR 3.1.8]
  - [URAC waiver] materials should address the basic process for seeking utilization review pre-certification/determination, appeals, and enrollee rights and responsibilities

V. RELATED CONTRACTS

TAB P: Memoranda of Understanding (MOU)

- [URAC waiver] signed copies of the Memoranda of Understanding (MOU) with each designated external appeals agency identified below [UR 6.1]:

  - MAXIMUS Center for Health Dispute Resolution
    50 Square Drive, Suite 210
    Victor, NY 14564-1099
    Contact: State Appeals Department
    Phone: (585) 425-5280
    Fax: (585) 425-5296

  - Massachusetts Peer Review Organization, Inc. (Masspro)
    245 Winter Street
    Waltham, MA 02451
    Contact: Jennifer Lelievre, Project Coordinator
    Phone: (781) 419-2777
    Fax: (781) 290-5784

TAB Q: Delegation Contract/Agreement

- if any utilization review is delegated to another agency, provide a signed copy of the contract/agreement that controls the delegated utilization review responsibilities [UR 3.1.2 b)]

TAB R: Liability Insurance

- evidence of current liability insurance [UR 3.1.11]